

ATTACHMENT 9

Sample CMS 1500 claim form for HealthCheck environmental lead inspection with educational visit

HEALTH INSURANCE CLAIM FORM										PICA																																																																																																																																																																																																																																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <div style="text-align: center; font-weight: bold;">1234567890</div>																																																																																																																																																																																																																																																		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <div style="font-weight: bold;">Recipient, Im A.</div>					3. PATIENT'S BIRTH DATE <div style="display: flex; justify-content: space-between;"> MM DD YY 05 21 01 </div>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																																																																																																																																																
5. PATIENT'S ADDRESS (No., Street) <div style="font-weight: bold;">609 Willow St</div>					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																																																																																																																																																																																																																																																
CITY <div style="font-weight: bold;">Anytown</div>			STATE <div style="font-weight: bold;">WI</div>		CITY			STATE																																																																																																																																																																																																																																															
ZIP CODE <div style="font-weight: bold;">55555</div>		TELEPHONE (Include Area Code) <div style="font-weight: bold;">(xxx) xxx-xxxx</div>			ZIP CODE		TELEPHONE (INCLUDE AREA CODE)																																																																																																																																																																																																																																																
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:																																																																																																																																																																																																																																																		
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																																																																																		
b. OTHER INSURED'S DATE OF BIRTH <div style="display: flex; justify-content: space-between;"> MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> </div>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																																																																																		
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																																																																																		
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE																																																																																																																																																																																																																																																		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																																																																																																																																																																																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																																																																																																																																																																																																																		
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) <div style="display: flex; justify-content: space-between;"> MM DD YY MM DD YY </div>			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE <div style="display: flex; justify-content: space-between;"> MM DD YY MM DD YY </div>			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION <div style="display: flex; justify-content: space-between;"> FROM MM DD YY TO MM DD YY </div>																																																																																																																																																																																																																																																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN																																																																																																																																																																																																																																																		
19. RESERVED FOR LOCAL USE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES <div style="display: flex; justify-content: space-between;"> FROM MM DD YY TO MM DD YY </div>																																																																																																																																																																																																																																																		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) <div style="margin-top: 10px;"> 1. <u>V20.2</u> </div>					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																																																																																		
22. MEDICAID RESUBMISSION CODE <div style="margin-top: 10px;"> 1234567 </div>					23. PRIOR AUTHORIZATION NUMBER <div style="margin-top: 10px;"> 1234567 </div>																																																																																																																																																																																																																																																		
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">A</th> <th colspan="2">B</th> <th colspan="2">C</th> <th colspan="2">D</th> <th colspan="2">E</th> <th colspan="2">F</th> <th colspan="2">G</th> <th colspan="2">H</th> <th colspan="2">I</th> <th colspan="2">J</th> <th colspan="2">K</th> </tr> <tr> <th colspan="2">DATE(S) OF SERVICE</th> <th colspan="2">To</th> <th colspan="2">Place of Service</th> <th colspan="2">Type of Service</th> <th colspan="2">PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th colspan="2">DIAGNOSIS CODE</th> <th colspan="2">\$ CHARGES</th> <th colspan="2">DAYS OR UNITS</th> <th colspan="2">EPSDT Family Plan</th> <th colspan="2">EMG</th> <th colspan="2">COB</th> <th colspan="2">RESERVED FOR LOCAL USE</th> </tr> </thead> <tbody> <tr> <td>01</td><td>05</td><td>04</td><td></td><td></td><td>12</td><td></td><td></td><td>T1029</td><td>EP</td><td></td><td>1</td><td>XX</td><td>XX</td><td>1.0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>01</td><td>05</td><td>04</td><td></td><td></td><td>12</td><td></td><td></td><td>T1002</td><td>EP</td><td></td><td>1</td><td>XX</td><td>XX</td><td>1.0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>										A		B		C		D		E		F		G		H		I		J		K		DATE(S) OF SERVICE		To		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE		01	05	04			12			T1029	EP		1	XX	XX	1.0										01	05	04			12			T1002	EP		1	XX	XX	1.0																																																																																																																																																									
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25. FEDERAL TAX I.D. NUMBER <div style="margin-top: 10px;"> 1234JED </div>			26. PATIENT'S ACCOUNT NO. <div style="margin-top: 10px;"> 1234JED </div>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE <div style="margin-top: 10px;"> \$ XXX XX </div>		29. AMOUNT PAID <div style="margin-top: 10px;"> \$ </div>		30. BALANCE DUE <div style="margin-top: 10px;"> \$ XXX XX </div>																																																																																																																																																																																																																																												
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <div style="display: flex; justify-content: space-between;"> <i>J.M. Williams</i> MM/DD/YY </div>					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <div style="margin-top: 10px;"> I.M. Billing 1 W. Williams Anytown, WI 55555 87654321 </div>																																																																																																																																																																																																																																													
SIGNED _____ DATE _____					PIN# _____ GRP# _____																																																																																																																																																																																																																																																		

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)